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PROGRAM DESCRIPTION

The Balanced Budget Act of 1997 created a federal children's health insurance program under Title XXI of the Social Security Act. The Child Health Insurance Program (CHIP) allowed states to create programs to provide health insurance coverage to children whose family income was as much as 200 percent of the federal poverty level, with some states allowed higher levels. Under this legislation, states could design programs through one of three options: by expanding their existing Medicaid program, by creating a stand-alone insurance program independent of Medicaid, or by combining the two. States are required to submit a plan for approval in order to participate in this program and must be able to provide state funds to match the federal dollars.

South Carolina began covering children August 1, 1997, through its new Partners for Healthy Children program (PHC). After a series of public meetings, South Carolina had

decided to expand its Medicaid program prior to the passage of the Child Health Insurance Program (CHIP). With the enhanced match rate available to the state October 1, 1997, the state could cover children ages one through 18 up to 150% of the federal poverty level, with an estimate of reaching 75,000 children. With a Medicaid expansion, children in the same families could now be on the same program and have the same doctor, which was a frequent comment from the public. Children were also given 12 months of continuous eligibility.

Prior to determining the impact of PHC, information has to be gathered and analyzed to ensure cost-effective program implementation and operation. The state is currently evaluating its Medicaid Management Information System to determine the type of data the system reports and what is not currently being captured. As part of the PHC evaluation, South Carolina will identify the perceptions people have of Medicaid, their willingness to enroll in PHC, utilization and association with a medical home and current types of health insurance coverage for households with children. South Carolina will also attempt to validate the estimates of uninsured children in the state.

For the first annual report we will assess the application, outreach efforts, and enrollment figures and discuss future plans for PHC. Future reports will evaluate the impact of the PHC program in terms of the strategic objectives, performance goals, and performance measures.

This report covers the first year and two months of Partners for Healthy Children, from August 1, 1997, through September 30, 1998. Over this period, South Carolina enrolled an additional 60,500 children into the Medicaid program.

BASELINE NUMBERS OF UNINSURED CHILDREN

South Carolina looked at several estimates of uninsured children in the process of formulating our State Plan for Federal Fiscal Year (FFY) 1997-98, including those by Employee Benefit Research Institute (EBRI), the Southern Institute on Children and Families (both of which used the CPS numbers for analysis) and the Current Population Survey (CPS). Since the FFY 1998 and subsequent annual allotments under the program are based on the average of three years CPS data, South Carolina decided to use the CPS as its official baseline for uninsured children under 200% of poverty. The official estimate for FFY 1998 was 110,000. Since our initial CHIP program was a Medicaid expansion to 150% of poverty, we needed a target estimate for the number of children we expected to cover with Partners for Healthy Children (PHC). We considered the ratio of the estimated number of children above Medicaid income eligibility levels but below 150% of poverty to those above Medicaid eligibility but below 200%. We then added a factor to estimate children 1-18 years who were income eligible for Medicaid but not enrolled and arrived at a baseline target for enrollment. That number was about 70% of the 110,000 uninsured children under 200% of poverty, or 75,000 children under 150% of poverty.

New CPS estimates published before the beginning of FFY 1999 indicated a higher estimate of 124,000 uninsured children under 200% of poverty. The FFY 1999 allotments were originally to have been based on the new CPS figures, but allotments were frozen at 1998 levels due to substantial fluctuations in estimates of the uninsured populations in states . We had anticipated originally that it would take two years to enroll our target population. However, given the rapid rate of enrollment our PHC program experienced in the first year-- through September, 1998, a net increase of over 60,000 children enrolled in Medicaid over our beginning enrollment and almost 15,000 more by mid-January--it is necessary to increase our target under 150%. Using about seventy percent of the difference between 124,000 and 110,000, our new baseline target becomes 85,000.

ENROLLMENT OF CHILDREN

During the period of August 1, 1997, through September 30, 1998, South Carolina increased its Medicaid net caseload of children by 60,500 through the PHC program. The combination of a simpler application process, an emphasis on insurance instead of welfare, and numerous outreach efforts resulted in enrollment of children at all poverty levels, including those who were eligible for Medicaid prior to the expansion but had not applied. By the end of September, about 60% of newly enrolled children were eligible due to the expanded eligibility standards under PHC, while the remaining 40% were eligible under the regular Medicaid standards. PHC, however, provided the conduit for the enrollment of all these children.

PHC APPLICATION

The Partners for Healthy Children application is one of the program's leading contributors to its success. The application and application process have significantly improved the image of the state's Medicaid program. Partners for Healthy Children has its own logo of five smiling children's faces. The application is a bright yellow-gold. The word Medicaid is mentioned once on the application, and only for the purposes of preventing current Medicaid recipients from reapplying. The features that have enabled South Carolina to reach over 60,000 children within the first year include making the application less complex, easier to access, allowing a mail-in option, and marketing the program as a child health insurance option instead of Medicaid.

The application has been greatly simplified. It consists of two double-sided pages: page one consists of the logo and a brief letter from the governor introducing PHC; page two has the income guidelines in an easy-to-understand chart; page three is the first page of the simplified application; and page four is about one half application and one half Rights and Responsibilities. The applicant is instructed to complete the application if their family income falls within the guidelines and to mail the completed application to Partners for Healthy Children. The only verification required of the applicant is proof of income. There is a toll-free number to call for assistance with the application. In cases where the family's income is slightly above the guidelines, they are instructed to complete the application anyway in hopes that income deductions will allow them to

qualify. Families can also still apply through their local Department of Social Services (DSS) offices.

DHHS has remained sensitive to needed changes on the application. Over time, improvements have been made to increase the response rate and to reduce the error or incomplete application rate. One change involved reordering the questions so that the request for proof of income came directly after the information about the applicant's work situation. A question was also added to ask where the person obtained the application. Initially, PHC was attempting to track its outreach efforts by the color of the application, but over time, this method became extremely cumbersome as more outreach efforts were added. If PHC expands the population it covers in any way, DHHS may consider changing the format of the application slightly to reach a different group of people.

To date, two-thirds of all applications for PHC have been processed at DHHS central processing center, with the others coming through the local DSS offices. Mechanisms are in place to promote customer satisfaction. The processing center will call an applicant twice before returning an incomplete application. When possible, information is obtained by telephone or facsimile to avoid delays in determining eligibility. The toll-free number encourages clients to call for assistance with the application and to obtain information on the PHC program.

Over the course of the first year of operation, approximately 72% of all applications were approved, 20% were returned to the applicant for various reasons, and 8% were denied. Of the returns, approximately 50% had no proof of income, which is why DHHS modified the application, and since then that number has significantly declined. Another 23% of the returns were because the child was already eligible. Other reasons included missing information on the children and not signing the application. Over time, the mail-in unit has worked to minimize these problems.

Literacy Review

South Carolina has a large illiterate or functionally illiterate population. Many of these people with children often do not access available benefits because the paperwork and processes are too complex. DHHS approached the Greater Columbia Literacy Council to assess the readability of the application and the promotional materials. The director of the Council explained that space, lists, and wide margins are key tactics when writing for low level readers. She found our application and marketing tools to be highly readable and friendly to basic readers.

The readability of the application was also analyzed using the Flesch-Kincaid software for Grammatik, a part of the Corel WordPerfect software, to determine how well the PHC application communicated necessary information to applicants. Readability refers to all variables that affect success in reading and understanding of instructions, informational letters, or the application. Overall, the application was rated extremely readable, with low vocabulary and sentence complexity.

Crowd Out

The application requests any health insurance that the parent and/or child may already have. The information is then verified using the current Medicaid third party liability (TPL) system. The definition of credible coverage in the CHIP legislation matches DHHS' TPL definition of coverage. Only 5% of eligible children actually have some form of credible coverage, and that coverage is used as the primary payor, with Medicaid being the payor of last resort. Enhanced matching funds are not used for these children.

PROMOTION AND COORDINATION

Public Meetings

DHHS, in conjunction with the Governor's office, held two public meetings to hear comment on the CHIP program, both its current operation and options for the future. Key representatives from both the House and Senate convened the meetings. On March 17, 1998, parents and advocates were asked to comment. Providers and state agencies were invited on March 24, 1998.

Both sets of presenters praised the implementation and operation of Partners for Healthy Children. PHC was actually the result of prior years' hearings. Most people also recommended that the state expand its program to 200%, with a few individuals commenting that the first phase should be well established before making changes. Suggestions for additional outreach efforts were also made, some of which DHHS implemented.

Other Interested Parties

The South Carolina Chamber of Commerce is another partner with DHHS. DHHS is exploring ways to survey their membership to determine levels of health insurance coverage among its members and their dependents. Since true rates of uninsurance are difficult to ascertain, the Chamber has agreed to assist where they can. They also inform their members of PHC's benefits to their employees.

The largest insurer in the state, Blue Cross/Blue Shield of South Carolina, maintains regular contact with DHHS, and is fully aware of PHC and its potential to expand. They are also interested in the impactvate market in general. In response, DHHS provides them regular updates. The South Carolina Managed Care Association has also been briefed and is interested in future developments of the program.

OUTREACH

There are too many programs that do not reach the people they are designed to benefit. South Carolina wanted Partners for Healthy Children to be different. Outreach, therefore, has been a central component of Partners for Healthy Children from the beginning. All efforts have been designed around the concept “to reach the people where they live.” This

new approach required enlisting the support of agencies, institutions, organizations, and businesses that were trusted in communities across the state and that had the potential for reaching families with children. This grassroots approach made applications available at such locations as pharmacies, physician offices, health clinics, hospitals, child care centers, schools, unemployment offices, private businesses, non-profits and other organizations. Outreach was also conducted at conferences and public fairs. Schools have been the most significant partner with over half of the applications resulting from their efforts. Increasingly, however, the "word of mouth" network is becoming one of our best tools to reach people.

Over two million applications have been distributed through the outreach efforts which will be delineated in the following paragraphs. Expenditures are mostly for staff time, printing and mailing of applications. The low-cost overhead can be attributed to utilizing local systems that were already in place and is directly related to the willing volunteers and grassroots efforts across the state.

Schools

- At the beginning of the 1997 and 1998 school years, applications were sent home with every child enrolled in school, grades pre-school through twelve.

- *Athletic Directors Association* endorsed PHC and sent a letter and applications to every AD in the state.

- *School Nurses Association* endorsed PHC and included information on the program in the June issue of the Association's newsletter.

- Local health workers work with school officials to enroll children during the school's registration period.

Government Agencies

- *Employment Security Commission* employees distribute applications to individuals seeking employment.

- *Department of Disabilities and Special Needs (DDSN)* distributes applications to families during home visits.

- *Department of Alcohol and Other Drug Abuse Services (DAODAS)* distributes applications to clients and has hosted an informational session about PHC for its clients.

- *Department of Parks, Recreation, and Tourism* community parks offices have applications available.

- *Department of Health and Environmental Control (DHEC)* contracts with DHHS to conduct outreach for PHC. Activities include but are not limited to:

- Health Districts share applications at community activities, i.e. health fairs and church related events.

- Health Districts distribute applications in non-traditional locations in the community, i.e. Laundromats, restaurants, hair and nail salons, and child care centers.

- Applications are distributed through the DHEC program Careline, which answers parents questions regarding health related topics. Callers are asked whether or not their children have health insurance.

- *Department of Social Services* staff distributes applications to families inquiring about other governmental programs.

- *DHHS'* Divisions of Aging and Community and Long Term Care (CLTC) staff take applications out into the field and share them with potentially eligible families.

Non-Profit Partnerships

- *Family Connection*, an organization that assists families of special needs children in finding health care and support, has volunteers who distribute applications to their clients and have worked with DHHS to develop a more family-friendly TEFRA application.

- Other Family Connection outreach includes: placing applications in doctors' offices, Laundromats, community centers, child care facilities, businesses, churches and temporary employee service centers.

- *Growing into Life* works with families in Aiken county to reduce the county's infant mortality rate. Distributing PHC applications have been incorporated in the organization's existing outreach efforts.

- *Hope for Kids* works to ensure every child is up-to-date in his immunizations and shares PHC applications with families during the organization's door-to-door campaigns. Applications are also distributed monthly to families through other outreach activities.

- *Commun-I-Care* coordinates health care for individuals who do not have insurance and do not qualify for Medicaid. Staff share applications with prospective clients and include applications in monthly mailings.

- *Adult Literacy Council* staff display applications and share them with clients.

- *Food Pantries* distribute applications with their temporary assistance.

- *Habitat for Humanity* displays posters and distributes applications with families applying for Habitat housing.

- *SC Fair Share* includes applications with outreach materials shared with the Hispanic community during door-to-door visits, as well as with other clients.

Faith Based

- Full support of the leaders of the *African Methodist Episcopal Church* and the *Baptist Educational and Missionary Church* who encouraged all pastors in their denominations to share information about PHC with their respective congregations.

- Applications available through the *United Methodist Church, Baptist Convention, Lutheran Church* and other denominations.

- Applications distributed to youth and parents during Youth Conferences.

- Applications distributed during church health fairs.

Pharmacies

- Pharmacy Association endorsed PHC and published numerous articles about the program in the association's newsletter.

- CVS, Eckerd, Kmart and Kroger pharmacies distribute applications at all locations in South Carolina.

- Various locally owned pharmacies distribute applications.

Physicians/Dentists

- Display posters and applications in waiting area.

- Some include application in mailings to patients.

- Front office staff knowledgeable about PHC.

Health Centers/Clinics

- *Rural Health Clinics* distribute applications to patients during office visits and at community activities.

- *Federally Qualified Health Centers (FQHCs)*

- Direct mailed uninsured clients (ages 0-18) who had received care at the Family Health Center in Orangeburg.

- Applications are distributed on site at all centers.

- *Free Health Clinics* staff share applications with patients.

Spanish Speaking Population

- Applications are available in Spanish and DHHS has bilingual staff who can assist individuals who call the toll-free number.

- Temporary Spanish posters developed by the Appalachia III Health District to be used in the Upstate.

- *March of Dimes*' Low Country branch works extensively with the Hispanic population and has incorporated PHC in its outreach efforts. Efforts include health fairs and other community events.

- Work with other non-profits and other community organizations who have existing outreach to the Spanish speaking community.

- *Migrant Task Force*s throughout the state share applications with the people they serve.

- *Greenwood United Ministries* hosts a weekly health clinic which serves a large number of migrants and other Spanish speaking individuals. Applications are distributed to families seeking care.

- Catholic Priests throughout the state have applications available and share them with families who may be eligible for PHC.

Other Minority Populations

- *Indian Population:* each family with children on tribal mailing list received an application and nurse on the reservation keeps applications on-hand.

- *Korean Population:* Family Service Center works with Korean exchange students at the University of South Carolina and has translated the PHC poster into Korean. Volunteers assist families in completing the application. Articles about PHC also appeared in a Korean newsletter.

Child Care

- All licensed child care facilities display applications and share applications with employees.

- All recipients of payment through the ABC voucher system for child care received an application in the mail.

Hospitals

- Outstationed eligibility workers are housed in many emergency rooms and assist families with completing the application.

- PHC is incorporated in existing outreach activities.

Housing Authorities

- Applications are available in offices and have been shared door-to-door.

Miscellaneous

- *Black Family Summit*: applications were distributed during the 1998 Conference. Presenters share information about the program's availability.

- *Select Health*: (a Health Maintenance Organization serving Medicaid families) displays PHC applications during outreach activities.

- *WIS Back to School Bash:* applications were shared with families participating in the Bash. A public service announcement ran during the fall promoting PHC.

- *Private Employers:* Chamber of Commerce shares information about PHC with its members. Various private employers share information about PHC with their employees who do not have access to health insurance for their children.

- *Alpha Kappa Alpha Sorority, Inc*.: Alumnae chapters are incorporating PHC into their existing outreach activities by distributing applications at churches and other locations in the community (i.e. businesses, restaurants.)

ACCESS TO MEDICAL HOMES

One of the major goals of CHIP is to provide uninsured children with access to medical homes. Since there is no benefit for a child to have an insurance card but no doctor, the linking of children to medical homes has been a major objective of PHC and the Medicaid program in general. The agency has been working with physician offices and professional medical organizations to recruit new Medicaid Providers and to encourage the establishment of medical homes. DHHS has developed or coordinated three medical home vehicles to complement the fee-for-service system: the Physicians Enhanced Program (PEP), the Healthy Options Program (HOP) and Health Maintenance Organizations (HMOs).

Recipients have their choice of how their care is delivered, either through one of these models or through the traditional fee-for-service method. The medical home vehicles are alternative reimbursement mechanisms designed to encourage physicians to provide medical homes for Medicaid recipients. Physicians accept responsibility for the provision

and/or coordination of primary, preventative, and/or specialty care, including providing and/or facilitating access to medical consultation and/or needed medical care 24 hours a day, 7 days per week. Doctors also maintain the client's medical history in order that continuity of care may be established. Both the PEP and HOP models have been extremely popular with providers and they continue to expand across the state.

There are 21 PEP practices located in five counties (Horry, Pickens, Florence, Greenville, and Sumter). There are 290 HOP providers in 21 counties (Abbeville, Aiken, Beaufort, Charleston, Cherokee, Dorchester, Edgefield, Florence, Georgetown, Greenville, Greenwood, Horry, Lancaster, Laurens, Lexington, Newberry, Oconee, Orangeburg, Pickens, Richland, and Sumter). There were two HMO providers operating in nine counties (Bamberg, Calhoun, Charleston, Darlington, Florence, Lexington, Marion, Orangeburg, and Richland). Fee-for-service is the only Medicaid program that is currently available in every county in South Carolina.

PERFORMANCE GOALS

The South Carolina Plan outlined five strategic objectives and eight performance goals that PHC would achieve. A discussion focusing on the current ability to document or obtain the performance measures follows. The purpose of this section is to look at the current ability to obtain data for the 2000 report.

Strategic Objective 1:

Reduce the number and portion of uninsured and under-insured children in the state.

Performance Goal 1.1

Market the *Partners for Healthy Children (PHC)* insurance program.

DHHS monitors marketing efforts through the number of applications distributed through non-traditional sites. The initial application, now referred to as the "old application", did not have a question asking the applicant the source from which the form was obtained. DHHS simply tracked by the color of the application. As explained previously, additional outreach efforts made detailed tracking difficult, and hence, the application was changed. There are still some circumstances that are difficult to track, however. When applications are photocopied or passed on from one friend to another, the original source is masked. DHHS does monitor the "word of mouth" and friend factor through Question #8.

DHHS also tracked the number of targeted outreach initiatives. As the earlier narrative explains, there were almost too many to count. **DHHS more than reached its goal of 10.**

Performance Goal 1.2

Enroll targeted low income children in *Partners for Healthy Children (PHC).*

The performance measure that was targeted for this particular measure was the percent of 75,000 targeted low-income children enrolled in PHC. The target for fiscal year 1998 was 50% or 37,500. This number is derived from the DHHS tracking system.

In the first year of operation (plus August and September 1997), **Partners for Healthy Children enrolled an additional 60,500 children in the Medicaid program.** This number included both children who would have been eligible under the former Medicaid income criteria and children who are newly eligible due to the expansion.

Strategic Objective 2:

Improve access for children to medical care delivered in the most appropriate setting.

Performance Goal 2.1

Decrease the overall percent of Medicaid/PHC children's emergency room visits for non-emergent conditions.

The performance measure is the percentage of Medicaid/PHC children seen in the emergency room for non-emergent conditions. The reported baseline for the state fiscal year 1997 was at 60%. The target was to decrease this by 2%. **Discontinuity in the methodology for coding non-emergent conditions will result in a need to recalculate a baseline for this measure. DHHS is currently reevaluating this measure and will report the new baseline and results in 2000.**

Performance Goal 2.2

Decrease uncompensated care delivered to children in hospital settings.

One of the performance measures is the percent of children's inpatient admissions without insurance as expected pay source. The baseline for the state fiscal year 1997 was 5.5% of inpatient admissions. The target was to decrease by 2% for fiscal year 1998. **The measure for FY 1998 was 4.1%, a decrease of about 25%.**

The second performance measure is the percent of children's emergency room visits without insurance as expected pay source. The baseline for the state fiscal year 1997 was 20.5%. The target for fiscal year 1998 is to decrease this number by 2%. **The measure for FY 1998 was 18.7%, which is an 8.7% decrease from the previous level.**

Strategic Objective 3

Establish medical homes for children under the Medicaid/PHC programs.

Performance Goal 3

Recruit and orient physicians for participation in HOP, PEP, and HMO programs.

The performance measure is the number of Medicaid enrolled practices and primary care physicians participating in medical home programs.

Baseline as of September 30, 1997:

HMO primary care physicians	291
PEP enrolled practices	3
HOP participating physicians	40

Target for September, 1998:

HMO primary care physicians	350
PEP enrolled practices	15
HOP participating physicians	200

As of September, 1998:

HMO primary care physicians	561
PEP enrolled practices	21
HOP participating physicians	290

The next performance measures is the number of Medicaid/PHC children enrolled in the HMO and PEP programs and the number of children receiving services through a HOP physician practice.

Baseline for fiscal year 1997:

HMO and PEP enrolled children	4,076
Children receiving HOP physician services	528

Target for fiscal year 1998:

HMO and PEP enrolled children	6,200
Children receiving HOP physician services	8,000

For fiscal year 1998:

HMO and PEP enrolled children	10,548

Children receiving HOP physician services 27,701

Strategic Objective 4:

Increase access to preventive care for PHC enrolled children.

Performance Goal 4.1:

Immunize pre-school children enrolled in PHC at the same rate as age-comparable groups enrolled in regular Medicaid.

The performance measure was the percent of pre-school children enrolled in PHC and regular Medicaid receiving all recommended immunizations at ages 2 and 5 years. The anticipated source of this data for regular Medicaid rates is not yet operational. The *slightly adjusted measure* will now be **the percent of pre-school children enrolled in PHC compared to the general population of pre-school children receiving all recommended immunizations at ages 2 and 5.**

This measure will require drawing age-appropriate samples from the XXI expansion group and linking their claims records to ascertain immunizations. DHHS will develop arrangements with an appropriate entity to draw samples and link claims in order to include results for this measure in the year 2000 report.

Performance Goal 4.2:

Deliver EPSDT services to children enrolled in PHC at the same rate as children enrolled in regular Medicaid.

The performance measure is the percent of PHC and regular Medicaid children ages 6 - 18 eligible for screening who receive recommended EPSDT screens. This age group was chosen because it is more difficult to get older children to comply with recommended screens. The baseline for fiscal year 1997 was a 43% completion rate of the due screens. The target for fiscal year 1998 was to maintain a 43% rate.

The actual screening ratio for regular Medicaid children aged 6 through 18 was .42 or 42% of expected screenings that were provided. The PHC children in the same age group had a slightly higher screening rate of 48% of expected screenings for FFY 1997-98.

Strategic Objective 5:

Improve management of chronic conditions among PHC enrolled children.

Performance Goal 5:

Decrease the incidence (#per 1000 children) of children hospitalized for asthma among Medicaid/PHC enrolled children through identification and dissemination of effective patient education and disease management strategies to physicians.

The agency is exploring ways to verify this information. The evaluator and methodology has not been determined but will be ready to report in 2000.

OTHER STUDIES

The agency has joined with the University of South Carolina College of Social Work to form the Partnership for Community and Organizational Services. The Partnership provides information and policy development support for the agency. This support includes evaluating and studying the PHC and Medicaid Managed Care components of the Medicaid program.

Currently the evaluation team is in the process of preparing for a client survey, which will sample parents of children enrolled in PHC, parents of children eligible for but not enrolled in PHC, Medicaid recipients enrolled in each of the three managed care options, and Medicaid recipients not enrolled in one of the options. The first phase of the survey, covering PHC enrollees and eligibles, will be conducted in early 1999. The second phase, covering the managed care populations, will occur in the fall of 1999. The survey will focus on the following constructs: access to health care; barriers to health care coverage; provision of a medical home; quality of care; ancillary services; preventive services; barriers to health care; and demographics.

The Partnership also arranged for sixteen questions to be asked on the Fall 1998 South Carolina

State Survey conducted by the Institute of Public Affairs at the University of South Carolina. There were three sets of questions asked. The first set was to establish the general public's attitudes towards Medicaid. The second set was to determine the health care coverage, the health care activities and the barriers to health care for the children of the respondents.

The first set of questions was answered by 813 to 822 respondents, with a sampling error of +/- 3.5%. The respondents were generally positive about the Medicaid program. Not quite 61% disagreed with the statement that Medicaid was only for poor people and nine out of ten said they would sign up for Medicaid if they could not afford other health care coverage. However, only one-third agreed with the statement that Medicaid clients receive the same quality of care as private pay clients.

The second set of questions was responded to by 315 respondents, all those in the initial sample who had responsibility for providing health care for a child in their home. The responses to questions by the 315 persons indicates that those who are enrolled in public programs such as Medicaid are under-represented in this sample. Findings for the second

set of questions should be interpreted with caution due to the small size of this group of respondents. These findings will be used as the beginning point for further study.

Among the respondents with children, 92.6% said they had some kind of health care coverage for their child. About two-thirds of these adults said that their employer or spouse's employer paid for all or part of the cost of this coverage. Over 95% said they have a place where they usually take their child for health care and about 85% have a personal physician for their child.

The Partnership will also conduct a provider survey of physicians involved in all service delivery options. It will focus on provider satisfaction, as well as their perceptions of the Medicaid program, PHC, and clients in general.

Follow up focus groups are planned with all populations to add greater qualitative information and context to the most important issues. They will also further explore findings of the surveys as unexpected issues arise.

In order to measure the relationship between welfare reform and the Medicaid program, DHHS also works closely with the Department of Social Services (DSS). DSS monitors the well-being of former welfare recipients--including insurance status--through quarterly sample surveys approximately a year after clients' cases close. Among children included in the survey, insurance coverage after leaving welfare was about 81% in the first two survey periods. Among adults, only 52% had coverage. Children's coverage, however, began to increase after implementation of PHC and was up to 91% in the most recent survey. Eighty-eight percent of children with coverage were enrolled in Medicaid.

FUTURE

South Carolina has enjoyed many successes during its first year and phase of its CHIP program. The goal was to ensure proper and successful operation of the initial expansion, and PHC has met the challenge. The state is currently in the process of examining how to assist children in families with income up to 200% of poverty.

DHHS is also collaborating with the South Carolina Health Alliance to apply for the Robert Wood Johnson "Covering Kids" outreach grant. We anticipate using those funds to try new outreach methods on hard to reach populations, such as adolescents and Spanish speaking children, as well as develop new marketing strategies to reach any expanded groups of children. If the state chooses to expand its program, a different marketing approach will be needed to appeal to the group with a higher level of income.

Finally, South Carolina will continue to improve access to health care services for children across the state with more physician partnerships and greater public awareness of PHC. As more children have health insurance, it is incumbent upon the state to work to ensure that these children will receive the benefits of that insurance.

Overall, South Carolina's experience with the Child Health Insurance Program has been an extremely positive one. People from all walks of life and from all corners of the state have praised this program for filling a need in the state. Many parents have written the governor to thank him for offering this help to working families. As the state looks to the future, it will strive to protect the progress made in the last year and to build on our successes.